

Partnership for Kids:
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Lions and Tigers and Lawyers, OH MY!
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LIONS & TIGERS & LAWYERS...OH MY!

A. THE SOCIAL WORKER

The social worker is the start to any investigation involving a child in foster care. The social worker possesses all of the names, addresses and telephone numbers of the key players. They have talked to the children and they already have a professional relationship with the Guardian Ad Litem, therapist and foster parents. Much of this information can't be obtained from any other source. The social worker is also the case leader. She will draft the plan for reunifying the children with their parents and be responsible for its implementation. She is the decision maker for many of the key decisions involving the child such as placements and visitations. An excellent technical assistance brief put out by the National Council of Juvenile & Family Court judges is attached as Exhibit A. This should give you some guidance on what questions might be asked of the social worker about the child's care.

Many social workers, particularly the experienced ones are surprisingly well trained and their opinions and observations should not be arbitrarily discarded.

Nevertheless, social workers are often new and inexperienced due to high turnover and those that stay are overworked and are underpaid and often suffer burnout. It is important to keep the social worker interested in your client's case and recognize if the social worker is brand new inexperienced.

B. THE FOSTER PARENTS

1. Insight. The social worker may spend a few hours a month with the child. A therapist an hour a week. But the foster parents will spend several hours each day with a child. That foster parent will learn the child's secrets, fears and habits. There is no better source of information about the child, than the foster parents.

2. Social Services is given 75 days to come up with a plan. The foster parents have to come up with a plan to handle the child immediately. In a surprising number of cases while the other professionals are struggling with possible solutions to children's problems, the foster parents have come up with a solution and already implemented it. It is much easier to take a solution that is already in place and working in the foster home and transfer it to the biological home than it is to come up with a new solution and implement for the first time in the biological home.

3. Monitoring. Even the most dedicated CASA won't check on their child every week for the course of the 18 months the child is in foster care. In fact, it will probably be 30 days between meetings. A lot could happen in that time. Serious events could go on that may require

your attention. A relationship for the foster parents could mean that you will receive a call when something significant happens in your child's life.

4. Counseling. While the foster parent is not a therapist, the foster parent will counsel the child and help the child make decisions. The trust relationship established that counseling could be more important than even the best of therapist.

5. What if. Whereas the vast majority of foster parents are some of the best parents on the planet earth and remarkably good people. There are times when problems erupt. Someone needs to monitor the situation with the foster parents to make sure that it is a healthy situation for your client.

C. PARENTS

Working with the biological parents is an exercise in patience. The biological parents are often angry and hostile. Imagine how you would feel if your children had been taken from you because you were accused of being such a poor parent that the children were actually being harmed by you. Realize that you have not walked in their shoes and your goal is to return the children to their house after making it a healthy place for the children. Adding more insult to this point seldom achieves that goal.

Substance Abuse: Although there is a myriad of issues that could be problems in the biological household, one you may pay particular attention to is substance abuse. Studies have shown that one of the parties i.e. one of the parents or the children have a substance abuse problem in 70 percent of the removals.

D. Reading Psychiatric Reports and Records

All psychiatric reports should be based on the DSM IV (Diagnostic and Statistical Manual of Mental Disorders, 4th Edition) published by the American Psychiatric Association, the undisputed bible of psychiatry. This manual is available in full and abridged forms from several sources including amazon.com. A full understanding of any psychiatric report is not possible without access to a DSM IV manual.

Most psychiatric reports include a five axis "multi-axial assessment". Axis 1 involves clinical disorders. Diagnoses on this axis focus on current level of functioning. In many cases, current behavior is clearly different from past behavior or level of functioning. These mostly involve disorders that drive the subject crazy. Depression, for example, is an Axis 1 disorder. Because the subject is bothered by an Axis 1 disorder, he is usually motivated to treat the problem, therefore most Axis 1 disorders are treatable.

Axis 2 disorders involve personality disorders. Personality disorders focus on life long patterns of disturbed or marginal behavior.

Most of these disorders are problems that do not bother the subject but drive those around him crazy. Because the subject believes he is

correct and the rest of the world is out of state, the subject is unlikely to be motivated to change these problems and treatment is difficult. Narcissism is an example of Axis 2 disorder. Axis 2 also includes mental retardation and autism.

Axis 3 involves general medical conditions which are listed because they often have a bearing on the person's psychological condition, i.e. Alzheimers disease or chronic pain.

Axis 4 involve the psychosocial and environmental stressors present in one's life and may affect the diagnosis, treatment and prognosis of mental disorders listed, e.g., problems with support groups (i.e. divorce, death of family member), problems with social environment (i.e. loss of friend), educational problems, occupational problems, housing problems, economic problems, problems with health care access, legal/criminal system interactions.

Axis 5 is a Global Assessment of Functioning. The GAF scale is a one number assessment from a scale of 1 to 100 of how the person is functioning. A copy of the GAF scale is found in Section VI as chart 7. This number gives a quick reference as to how severe the evaluator rates the subject's impairment.

**Percentage of U. S. residents who have ever had
a psychological disorder.**

| <u>Disorder</u> | <u>Black</u> | <u>Hispanic</u> | <u>White</u> | <u>Men</u> | <u>Women</u> |
|---------------------------------------|--------------|-----------------|--------------|------------|--------------|
| Substance Abuse | 13.8% | 16.7% | 13.6% | 23.8% | 4.6% |
| Generalized Anxiety | 6.1% | 3.7% | 3.4% | 2.4% | 5.0% |
| Phobia | 23.4% | 12.2% | 9.7% | 10.4% | 17.7% |
| Obsessive- Compulsive | 2.3% | 1.8% | 2.6% | 2.0% | 3.0% |
| Mood Disorder | 6.3% | 7.8% | 8.0% | 5.2% | 10.2% |
| Schizophrenia | 2.1% | 0.8% | 1.4% | 1.2% | 1.7% |
| Antisocial Personality Disorder | 2.3% | 3.4% | 2.6% | 4.5% | 0.8% |

Common Psychological Disorders

DSM major organizational categories

1. **Anxiety disorders:** intense maladaptive anxiety or anxiety-related behaviors

***panic disorder:** repeated, sudden panic attacks - intense apprehension, usually with physical symptoms.

***phobia:** persistent irrational fear of a person, place or situation.

***obsessive compulsive disorder:** combine obsessive or intrusive irrational thoughts, ideas or impulses that repeatedly well up in one's mind with compulsive or repetitive rituals such as hand washing, counting, checking, hoarding or arranging. This disorder occurs when an individual experiences obsessions and compulsions, which last more than an hour each day, in a way that interferes with his/her life. Sufferers experience "pathological doubt". They are unable to distinguish between what is possible, what is probably, and what is likely to happen.

***posttraumatic stress disorder:** follows life-threatening trauma with psychic numbing or hypersensitivity and intrusion (or avoidance) of trauma-related thoughts and feeling. Denial and avoidance facilitate the development of PTSD. People often experience anxiety or irritability, flashbacks, difficulties sleeping or concentrating, and/or an increase in arousal or sensitivity to their environments.

***Generalized anxiety disorder:** general unfocused excessive anxiety.

2. **Mood Disorders:** moods that interfere with functioning and which cause significant distress

***major depressive:** significant down periods accompanied by lack of interest in life, sleep disturbances, loss of energy, and negative thoughts.

***dysthymia:** long-lasting pattern of moderately "down" moods that still permit normal functioning, mild form of major depression.

***seasonal affective disorder:** (SAD) a cyclically recurring mood disorder characterized by depression, extreme lethargy, increased need for sleep, hyperphagia, and carbohydrate craving; it intensifies in one or more specific seasons, most commonly the winter months, and is hypothesized to be related to melatonin levels.

***bipolar disorder:** alternating extreme "up" and "down" periods, both of which interfere with normal functioning. One percent of the population suffers from this disorder.

3. **Schizophrenia:** disturbed thinking, perceptions, emotions, and actions...usually accompanied by psychosis (a loss of touch with reality that affects all areas of one's life). Schizophrenia literally means "split-mind" .. not in the multiple personality sense but in a schism between thoughts and emotions; perceptions and reality. Symptoms include disturbed thinking (loss of fluency in thought & speech), in particular delusions (firmly held belief with no basis in reality that is not shared by others and which interferes with general functioning). Delusions, hallucinations, disturbed emotions. Most of those affected with this condition respond to drug therapy, and many are able to lead productive and fulfilling lives.

***paranoid type:** delusion of persecution and/or delusion of reference.

***catatonic type:** disturbances of movement range from gross overactivity and excitement to marked retardation and even stupor with mutism. Posturing may occur, and the patient may take up a bizarre position (crucifix, or head raised several inches from the pillow) for prolonged periods. Extreme negativism or automatic obedience is sometimes seen. Mannerisms such as a mincing gait, grimaces, or overemphasis of normal movements are more common. Chemotherapy and improved individual management have made severe catatonic symptoms increasingly rare.

***disorganized (hebephrenic) type:** disorganized behavior and speech; flat or rapidly changing inappropriate emotion.

4. **Eating disorders:** distorted body image, body dissatisfaction, and disturbed eating behavior

***anorexia nervosa:** efforts to minimize caloric intake driven by an intense and irrational fear of weight gain.

***bulimia nervosa:** binge/purge; laxatives, diuretics, and/or exercise.

5. **Somatoform disorders:** physical symptoms that have no medical cause

***hypochondriasis:** minor symptoms seen as indicative of serious illness.

***conversion disorder:** sudden loss of function of a body part without medical illness.

6. **Dissociative disorders:** a division of consciousness into multiple levels of awareness - interferes with functioning (e.g. of memory and/or identity).

***depersonalization:** one's body does not belong to one's self.

***psychogenic amnesia:** inability to recall personal information following a psychological trauma.

***psychogenic fugue:** in dissociation, travels away from one's usual surroundings followed by psychogenic amnesia for the experience.

***dissociative identity disorder:** splitting of the personality into two or more distinct personalities of which only one is dominant at a time.

7. **personality disorders:** an enduring rigidly inflexible personality that causes distress or limits functioning and leads to violations of social norms. It causes distress or limits effective functioning.

***paranoid personality disorder:** characterized by pervasive (spread throughout) distrust and suspiciousness of others. These people rarely

become close to others or confide in them, often refuse to disclose personal information to anyone, bear grudges, and retain hostile feelings over imagined insults and slights. They devote time to gathering evidence of the malevolence (malicious; having or exhibiting ill will) of others and often questions the loyalty, fidelity, or intention of spouses, family members, or others. The condition differs from paranoid schizophrenia or delusional disorder of the persecutory type in that they include psychotic symptoms such as delusions and hallucinations.

***antisocial personality disorder:** violate the rights of others, usually without feeling guilt - also known as manipulative or psychopathic personality disorder.

***borderline personality disorder:** emotionally volatile, unable to cope with being alone, profoundly confused about their identities.

***obsessive compulsive personality disorder:** condition characterized by a chronic preoccupation with rules, orderliness, and control.

8. other problems:

***Attention Deficit Disorders (ADD/ADHD):** are characterized by difficulty with sustaining attention and focusing on information for long periods of time, impulsivity and/or hyperactivity. Although these are considered to be core symptoms, all three characteristics are not necessarily present in those affected. Symptoms are generally first manifested early in childhood and may persist in varying degrees throughout adult life. The difference between ADD and ADHD is the absence or presence of hyperactivity (ADHD with hyperactivity). ADD is a medical diagnosis, and people diagnosed with ADD are often prescribed medication to stabilize attention and activity levels.

Common Psychological Tests

There are probably hundreds of psychological tests used in the United States today. A few of the more popular are as follows:

I. The 16 Personality Factor Questionnaire - 5th Edition

Assesses the level of 16 personality traits in individuals 16 years and older. The 5th edition measures levels of warmth, abstract thinking, emotional maturity, dominance, and 12 additional primary personality traits, along with 5 global factors; extraversion, anxiety, tough-poise, independence, and control.

(a) Beck Depression Inventory II (BDI-II)

Self-report personality inventory to screen for severity of depression in adults. Age's adolescent to adults. Self-administered, 15-20 minutes to complete.

(b) Minnesota Multiphasic Personality Inventory - 2nd Edition (MMPI-2)

An empirically based test of adult psychopathology designed to assess the major symptoms and signs of social and personal maladjustment commonly indicative of disabling psychological dysfunction. By far the most widely used test. Age range: adults (adolescent test also available).

(c) *Millon Clinical Multiaxial Inventory - III (MCMI-III)*

The MCMI is a self-report instrument designed to assess DSM-IV related personality disorders and clinical syndromes coordinated with Millon's theory of personality. This instrument provides insight into 14 personality disorders and 10 clinical syndromes. It was developed for use with adults who are seeking mental health treatment and who have at least eighth-grade reading skills. Age range: adults.

(d) *Parenting Satisfaction Scale (PSS)*

Forty-five item standardized assessment of parents' attitudes toward parenting. Scores...define, compare, and communicate levels of parenting satisfaction in three domains: satisfaction with spouse/ex-spouse parenting performance, satisfaction with the parent-child relationship, and satisfaction with parenting performance. Self-reporting. 20 minutes to complete.

(e) *Parenting Stress Index (PSI)*

Self-report inventory for parents of children younger than 10 to measure the degree of stress in the parent-child relationship. Self-administered, 20-30 minutes to complete.

(f) *Rorschach*

Widely used projective technique with scores based on the examinee's responses to 10 unique inkblot designs. The technique is useful in diagnosis and treatment planning for individuals with a wide variety of psychological problems and psychiatric disorders. Age range: 5 years to adult.

(g) *Rotter Incomplete Sentences Blank*

A projective technique requiring examinees to complete 40 sentence stems as a method of personality assessment. Age range: high school through adult.

(h) *Thematic Apperception Test (TAT)*

Useful in the personality assessment of children and adults. The respondent's stories and descriptions of 31 pictures reveal some of the dominant drives, emotions, conflicts, and complexities of his or her personality. Age range: children and adults.

(i) *Wechsler Adult Intelligence Scale Revised (WAIS-III)*

11 subtest intelligence test for adults, grouped into verbal and performance scale. The Wechsler Adult Intelligence Scale is the most widely used test of general intelligence in the United States. The primary role of the WAIS is to evaluate any potential loss or decline in overall intelligence or aspects of intelligence that may be associated with brain disease or injury. Many patients with brain injury or disease do not show a significant decline in general intelligence. Some professionals use the WAIS in conjunction with a series of other tests such as the MMPI, 16PF, Rorschach and TAT to more fully understand the personality and functioning of patients. The WAIS is biased and heavily influenced by United States history, culture, and educational systems. Ages 16-74. Individually administered. 60-75 minutes to administer for a trained examiner.

(k) *BPS (Bricklin Perceptual Scales)*

A research-based custody test which measures a child's perceptions of each parent in four critical areas: competency, supportiveness, consistency, and admirable traits. Typically used on children age 6 and up. The BPS is made up of 64 cards, each about the size of a business envelope (3.5" by 8.5"). On one side of every card is a horizontal line. It is aligned with a scoring grid on the other side. The child sees only the lines; the examiner sees the test questions and the scoring grids. Each card is placed in a cardboard box on a piece of styrofoam, with the horizontal line facing up. In response to a questions, the child punches a hole through the line using a stylus pen. The BPS scoring sheet groups the test questions in four main areas, measuring the child's perceptions of each parent's ability to be: (1) a good role model for the skills of competency; (2) a source of warmth and empathy; (3) consistent; and (4) a role model for other admirable traits.

(l) *PORT (Perception-of-Relationships Test)*

The Perception-of-Relationships Test measures how close a child feels to each parent, and the positive and negative impacts of each relationship. Typically used on children age 3 years, 2 months and up. Like its companion test, the Bricklin Perception Scales (BPS), the POT is a data-based projective test, where the data base has been developed specifically to assist informed custody decision making. The test is made up of seven tasks (mostly drawings) that measure the degree to which a child seeks to be psychologically "close" to each parent, and the strengths and weaknesses developed as a result of interacting with each parent.

Specifically the PORT measures:

1. The degree to which a child seeks psychological "closeness" (positive interactions with) each parent.

2. The types of actions tendencies (dispositions to behave in certain ways e.g., assertively, passively, aggressively, fearfully, etc.) - adaptive as well as maladaptive - the child has had to develop to permit or accommodate interaction with each parent.

It is particularly useful in custody decision making because it sheds light on the degree to which a child actually seeks interaction with a given parent, and reflects the degree to which he or she has been able to work out a comfortable, conflict-free style of relating to each parent.

(m) *PASS (Parent Awareness Skills Survey)*

The Parent Awareness Skills Survey reflects the sensitivity and effectiveness with which a parent responds to typical childcare situations. Its 6 scores pinpoint parental awareness of:

- *the critical issues in a given situation;
- *adequate solutions;
- *the need to communicate in terms understandable to a child;
- *the desirability of acknowledging a child's feelings;
- *the importance of the child's own past history in the present circumstance; and
- *the need to pay attention to how the child is responding in order to fine tune one's own response.

(n) *PPCP (Parent Perception of Child Profile)*

The PPCP elicits an extensive portrait of a parent's knowledge and understanding of a specific child. It helps the evaluator assess the degree to which a parent's perception: (1) are accurate; (2) compare to other sources; (3) reflect genuine interest in a child. The PPCP also assesses the irritability potential of a parent towards a specific child. The Parent Perception of Child Profile offers a parent an opportunity to express what he or she knows about a particular child in a wide variety of important life areas.

Responses are gathered in eight categories:

- *interpersonal relations
 - *daily routine
 - *health history
 - *developmental history
 - *school history
 - *fears
 - *personal hygiene
 - *communication style

The PPCP can be evaluator-administered or self-administered.

One main use of the PPCP is to compare the responses of selected respondents, e.g. the two parents. Comparisons can be made in several ways, including accuracy and depth of knowledge in any given life area, especially one (or several) deemed critical to a particular child, and the feelings and attitudes expressed.

E. WORKING WITH A GUARDIAN AD LITEM

1. Get the Guardian Ad Litem interested.

The Guardian Ad Litem is an advocate for the child (the same as you), but has the added bonus that he or she can issue subpoenas, cross examine witnesses, present reports and arguments to the court and do everything else an attorney can do. This person can be a powerful ally for your child, however, many times the Guardian Ad Litem is passive. Establish communication early. Let the attorney know the points that concern you and get the Guardian Ad Litem interested.

2. Consider the Guardian Ad Litem as your attorney.

Since the Guardian Ad Litem and you both have the same mission, the two of you should work together toward that mission. Don't hesitate to ask the Guardian Ad Litem to explain matters of law to you or to try to enlist their assistance to get records or subpoena witnesses.

F. PARTY'S ATTORNEY

1. Learn to recognize a party's attorney. Make sure to look at the hat, not the face and not the smile. The very friendly and cooperative Guardian Ad Litem yesterday could well be a party's attorney today and with the new job comes a new person. While no lawyer should lie to you, a party's attorney will probably not tell you things that are unfavorable about this client, and in fact may be prohibited from releasing certain information. The party's attorney may actually work against you and try to sabotage your efforts. This doesn't mean that a party's attorney is useless or evil. Far from it. They are very valuable tools in the system, but required a special degree of handling and care.

2. Don't alienate a party early if possible. The surest way to get a child back from foster care is to work with social services, CASA and the other professionals to achieve the plan. A good attorney therefore, will try to appease you and keep you informed and in the loop. That is until he hears the magic words that you are not going to be of assistance to his client. At that point, his or her job is to thwart your efforts. Therefore, try not to say those words until as late in the game as possible. At least make them believe that you still have hope for their client and they will try to work with you.

3. The attorney is an information source.

A party's attorney can be a good source for one sided information. No they won't give you the complete picture, but they will often organize and present excellent information about the good things about their client and the bad things about competing interests. This can be extremely helpful in understanding the case as long as you realize that this is an incomplete picture.

4. The party's attorney is an ally. Often in a case you are frustrated with the parents reluctance to follow your suggestions. Talking to their attorney may be the leverage that you need to get your thoughts into the parents skull. A good attorney will be very blunt with clients, telling them what they need to do to win a case and

probably has a level of trust with his clients, that you can't achieve. The attorney desperately wants you on his side and will try to enforce your reasonable request.

5. Watch for tricks.

Advocating for a client does not begin and end in a courtroom. Once the attorney senses that you are not going to be helpful to his client, he needs to neutralize you. That can be accomplished through one of several methods. The first would be alienation. If you don't have access to the parents or their information, then your opinion is diluted. If you are called as a witness, the first cross examination question would be "Mr. Smith, you haven't talked to my client in six months, have you? So you don't have any first hand knowledge of their situation now do you?" The next would be to promote a civil war, one professional against the other. The last method is what I call the domino effect. The attorney obtains favorable evidence from one professional, say the child's teacher, and gets a letter from the teacher saying that the child is doing well in his client's care. The attorney then quickly takes that evidence to the child's therapist, and tries to get the therapist to give a favorable letter loosely based on the teacher's letters. The attorney then takes the letters of the teacher and the therapist to the Guardian Ad Litem, and then to the Social Worker. If he is fortunate and skillful he might be able to turn one piece of favorable evidence into five favorable reports. When your unfavorable report comes out, the dominoes have already fallen and yours is a lone dissent.

The way to combat all these tactics is to keep a good communication between the professionals. It is hard to turn the professionals against each other if they keep good communication and talk to each other about the case and understand each other's problems. Interim multidisciplinary meetings is often a good idea as are frequent updates. A CASA can be very valuable as a facilitator for this information flow.

G. DEALING WITH THE JUDGE

Don't rip the robe off. A Judge by definition is an older attorney who has been around many years and has climbed to the top of his profession by demonstrating wisdom and maturity. He has paid his dues and made many sacrifices to get to his position of power as the ultimate decider of contested matters. Do you really think that he is now going to abdicate that power and let you make the decisions just because you write in your report "in my opinion, I think ...". Such a tactic is referred to as ripping the Judge's robe off. You are attempting to substitute your judgment for his. Judges generally do not appreciate this activity. Nevertheless, Judges, do not interact with the parties and are hungry for evidence. Your first hand observations and witnesses and exhibits brought to court can be very valuable, and appreciated.

H. CASA

1. Don't try to be what you are not.

You are not a doctor so don't try surgery. Likewise, you are not a social worker or lawyer or a therapist and to play one is a mistake.

2. Realize what you are.

Recognize your strengths. You have eyes and ears and can make first hand observations. You have life experiences to what you can bring to a case. You can help the professionals communicate with each other and help bring information to the various professionals to help them make the right decisions and recommendations. Remember the best lawyers don't testify, but must win their case with evidence. You can do the same thing.

3. Motivate others.

One of the most important things that you can do on a case is to motivate the professionals to do their job to the best of their ability.

Unfortunately, throughout the foster care area, burnout is a problem. One a person by person, case by case cases you can do much to help your clients by inspiring the professionals to use their knowledge and skills to help the foster care child. You can also do this as an organization with awards and recognition.

(1) *Wiring:*

Every home inspection should include an inspection of the breaker (fuse) box. There are several items which should be checked.

The box should be rated for 150 or 200 amps. None of the breakers should be flipped off. This usually indicates an overloading or a short. If the breaker is flipped off, inquire as to the reason before attempting to turn it back on. It is better to learn the reason from the homeowner than from the investigation by the fire department.

An electric hot water heater should have a breaker of at least 30 amps. The kitchen stove should have a breaker of 30 to 50 amps. Any heaters or heat pumps should be on a separate circuit.

Lights or outlets may be on a 15 amp circuit or a 20 amp. Fourteen gauge wire may be used but may not have greater than a 15 amp circuit. Twelve gauge wire may operate dehumidifiers, refrigerators, air conditioners, and portable heaters and can utilize up to a 20 amp circuit breaker.

If the GAL is inspecting a modern home wired by a certified electrician, the chances for a problem is slight unless the homeowner has modified the system. On the other hand, problems often occur when dealing with an older home with cloth covered wiring and a fuse box instead of a circuit breaker box.

The typical fuse box on older homes was only 60 amp and contained 4 fuses. This system was designed only for electric lights and not refrigerators, microwaves, air conditioners, computers, portable electric heaters, or hair dryers. Many homeowners (and landlords) solve this problem by rendering the fuse box useless. The two most popular ways of doing this are to: screw a 30 amp fuse into a 15 amp spot or to put a penny behind the fuse to bypass the fuse entirely. Both methods are dangerous.

(2) *Lead Paint:*

Prior to the 1970's a great deal of homes were painted with lead based paint. Lead may cause a range of health effects, from behavioral problems and learning disabilities to seizures and death. Children 6 years old and under are most at risk because their bodies are growing quickly.

The problem of lead based paints has been vastly underrated. In 1978, there was nearly four million children with elevated blood lead levels in the United States. Although that number has dropped to 890,000 children in the 1990's, the number is still in epidemic proportions.

Lead based paint has not been used since 1978. If a GAL has reason to believe that the home is older than 1978, then lead based paint is an issue and any peeling or chipping paint should be taken seriously. Many homeowners are not worried about the paint as they have

repainted since 1978. This confidence is misplaced as peeling paint usually contains multiple layers of paint.

The danger of lead based paint is only present when peeling paint chips are consumed. This usually only presents a danger to small children as teenagers should know better. Nevertheless, it poses a sizable potentially irreversible danger to the small child. Peeling paint is most prevalent on the exterior of the home but can occur anywhere. Other danger spots are near plumbing fixtures and on window sills.

(3) *Ground Fault:*

Ground fault interrupters (GFI) are designed to protect from electrical shock by interrupting a household circuit when there is an abnormal diversion of current from the "hot" wire occurring. Such a current might be flowing in the ground wire, such as a leakage current from a motor or from capacitors. More importantly, that current diversion may be occurring because a person has come into contact with the "hot" wire and is being shocked.

GFI's are required by the electrical code for receptacles where water is present (in bathrooms, some kitchen receptacles, some outside receptacles, and receptacles near swimming pools). The horror story scenarios which led to these code requirements are things like dropping a hair dryer or a portable radio into a bathtub with a person causing electrocution. A typical circuit breaker interrupts the circuit at 20 amperes, but it takes only a small fraction of the circuit breaker load to electrocute a person in such a scenario. The GFI is designed to detect currents of a few milliamperes and trip a breaker to remove the shock hazard.

A GFI looks like a regular electrical outlet but with a "test" and a "reset" button in the middle of the outlet. To test to see if the outlet is working properly, press the test button. If the reset button pops out, it is in working order. Press the reset button to reactivate the outlet.

(4) *Poisons:*

Poisoning is still a major cause of death and injury to small children. The bathroom and kitchen should be checked to see if all pharmaceuticals are in tamper proof bottles and all cleaners and drugs are out of the reach of small children.

(5) *Railings:*

All railings should have no more than six inches between pickets. Any greater space would allow a child to squeeze through and fall. Most builders recommend even less open space. Minimum height of the railing should be not less than 36 inches.

(6) *Heaters:*

There are several warning signs which a diligent GAL should look for when examining the home's heating system. The first of which is whether the heating system is safe for small children. Baseboard electric heat is almost never appropriate around small children as it is

not properly shielded. Portable space heaters need shielding or to be put in an area where the small child cannot reach. Any home that is entirely heated by space heaters should raise a red flag. This is particularly true with an older home with fuse boxes. Space heaters have a tendency to overload the wiring and create a fire hazard. Wood stoves should have a sufficient pad underneath to prevent fire by sparks and should have no flammable objects within 2 feet. Kerosene heaters and other heaters designed for outdoor use should not be used indoors.

(7) *Plumbing:*

The GAL should check plumbing fixtures to see that they are in working order. If the house is on septic system, care should be taken to see that the drains work. If the toilets do not flush properly, the drains are too slow, or an odor is detected, the septic system may be in need of service or replacement.

(8) *Pets:*

Any dog can pose a danger to a small child. The GAL needs to inquire about and meet the pets to evaluate their propensity for injury. The GAL also needs to ask to see a cat or dog's rabies vaccination certificate.

(9) *Dangerous or Attractive Objects:*

Certain objects can be of danger to a child at any age. The GAL should always inquire about firearms and how the firearms and ammunition in the house are stored. Alcoholic beverages should not be stored within the range of children. With a small child, breakable items or items that are small enough to fit within the mouth of a small child should be high enough that they are out of reach of the child.

(10) *Basement:*

Every home inspection should include a trip to the basement or a look under the crawl space if possible. The GAL should look for unusually large cracks in the wall or floor indicating foundation problems, water marks on the walls or ceiling indicating flooding, the presence of a smoke detector, and what is stored in the basement. When people know someone is coming to inspect, they will often hide embarrassing items in the basement. The basement is also the best place to determine the type of wiring used in the home.

(11) *Smoke Detectors/Carbon Monoxide Detectors:*

Smoke detectors cost little but save thousands of lives each year. It is recommended there be at least one smoke detector per floor.

Any spot that is normally enclosed to air flow (such as an attached garage) should be considered a separate floor even if it is on the same level. As smoke rises with heat, smoke detectors should be placed at as high a position as possible. Smoke detectors should also be placed close enough to bedrooms so that it would awake the occupants in time to escape or fight the fire.

There are basically three elements to a smoke detector: (1) a device to detect smoke, (2) an alarm or buzzer, and (3) the power source. The most likely source of a malfunction is with the power source as most smoke detectors have a battery. Even those which are

"hard wired" to the house current usually have a battery backup. The alarm and primary power source can be tested simply by pressing the test button. A test of the actual smoke detector in the system requires exposing the system to smoke. The back up power source (if any) can be tested by switching off the smoke detectors at the fuse box and pressing the test button.

If the heating system of the dwelling utilizes gas or oil heat, a carbon monoxide detector is also recommended. The same principles set forth above for smoke detectors also are applicable to carbon monoxide detectors.

(12) *Fire Extinguishers:*

A home fire can double in size every 30 seconds. That means what started as a grease fire on a stove can burn out of control in under 3 minutes. In fact, it only takes 5 to 10 minutes for a two-story home to become totally engulfed in flames. Time is critical. The availability of a reliable fire extinguisher can make the difference. Most portable fire extinguishers have a short range of 6 to 10 feet and discharge completely in a very short time of 8 to 10 seconds. Although the average home fire extinguisher (in theory) is rated to fight a fire that is a maximum of 10 feet by 10 feet, they are in reality only appropriate for fighting fires caught in the early stages. Portable extinguishers will do little against large or established fires. However, many (if not most) fires are detected very early and could be extinguished by quick action.

Most fires are "A" fires (wood, cloth, paper, rubber and plastics). Nevertheless, most home fire extinguishers are only "BC" rated (gasoline and electrical). The last thing anyone wants to be doing in an emergency is reading the label on the extinguisher to see if it is right for his type of fire or attempt to extinguish the blaze with the wrong type of extinguisher.

When checking a fire extinguisher, most have a simple dial on which to read the pressure. The dial will indicate whether the extinguisher is fully charged or needs to be recharged or replaced. Some have a small pin or button. Check those by pressing the pin or button. If there is pressure on the pin or button and it pops back out, the fire extinguisher is charged. If not, the extinguisher needs to be replaced.

The extinguisher should be placed in a convenient location, but away from any portable fire source. For example, if the homeowner places the extinguisher too close to the stove, it would simply be lost in the fire.

(13) *Scalding:*

Each year in the U.S., approximately 1.2 million people seek medical treatment for burns. Approximately 50,000 are hospitalized. One third to one half of these are under 18 years old. Children from birth to age 4 account for nearly 50% of all pediatric burns. After age 4, the incidence of burn injuries declines only to rise again in adolescence as individuals enter the work force. (Case Based Pediatrics

for Medical Students and Residents. Department of Pediatrics, University of Hawaii John A. Burns School of Medicine) According to the American Hospital Association, more than 100,000 cases of scalding from hot water occur each year. More than 35,000 children, most of them 5 or younger, are treated each year in hospital emergency rooms for tap water scald burns according to the National Safe Kids Campaign. The National Coalition to Prevent Childhood Injury says scald burns account for about 100 deaths a year, most of them children under 5 or adults older than 65.

There are national standards set forth by the major plumbing code making bodies which specify a maximum temperature of 120 degrees for delivered hot water. Since the problem cannot be eliminated, various authorities and manufacturers are hoping to mitigate it by having the temperature of the water lower at the time of the incident. A hot water tank setting of 120 degrees rather than 140 degrees allows a bather significantly more time to react and by moving away or manually adjusting the water before burning occurs. This is particularly true of the very young and the elderly. If a GAL cannot hold his or her hand under tap water for a least 6 seconds after the water temperature has reached its maximum, the water is too hot. The tap temperature of water can also be tested with a simple thermometer.

The Consumer Product Safety Commission and the plumbing industry have published a voluntary standard which states that the maximum allowable temperature at the water outlet to the bathing area should be 120 degrees F.

| <u>Celsius Temperature</u> | <u>Fahrenheit Temperature</u> | <u>2nd Degree Burn No Irreversible Damage</u> | <u>3rd Degree Burn Permanent Injury</u> |
|----------------------------|-------------------------------|---|---|
| 45 deg. | 113 deg. | 2 hours | 3 hours |
| 47 deg. | 116.6 deg. | 20 minutes | 45 minutes |
| 48 deg. | 118.4 deg. | 15 minutes | 20 minutes |
| 49 deg. | 120 deg. | 8 minutes | 10 minutes |
| 51 deg. | 124 deg. | 2 minutes | 4.2 minutes |
| 55 deg. | 131 deg. | 17 seconds | 30 seconds |
| 60 deg. | 140 deg. | 3 seconds | 5 seconds |
| 65 deg. | 150 deg. | 2 seconds | 3 seconds |
| 70 deg. | 158 deg. | 1 second | 2 seconds |

These figures are for adults. Children scald much faster.